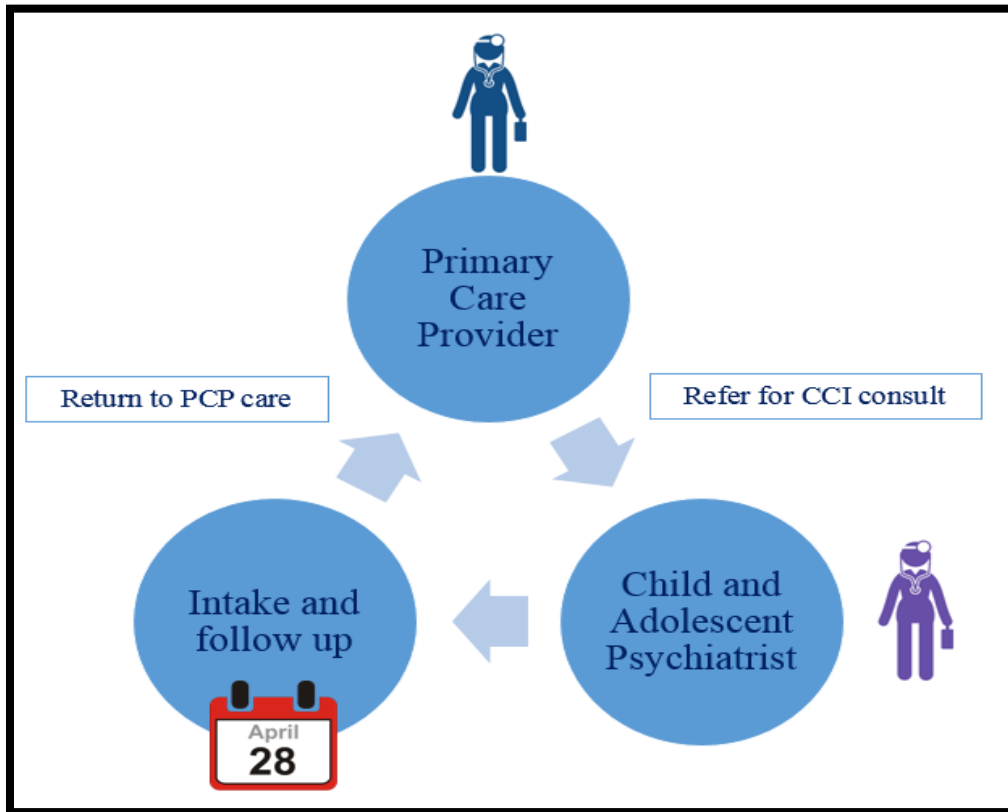


Collaborative Care Psychiatry Consultation

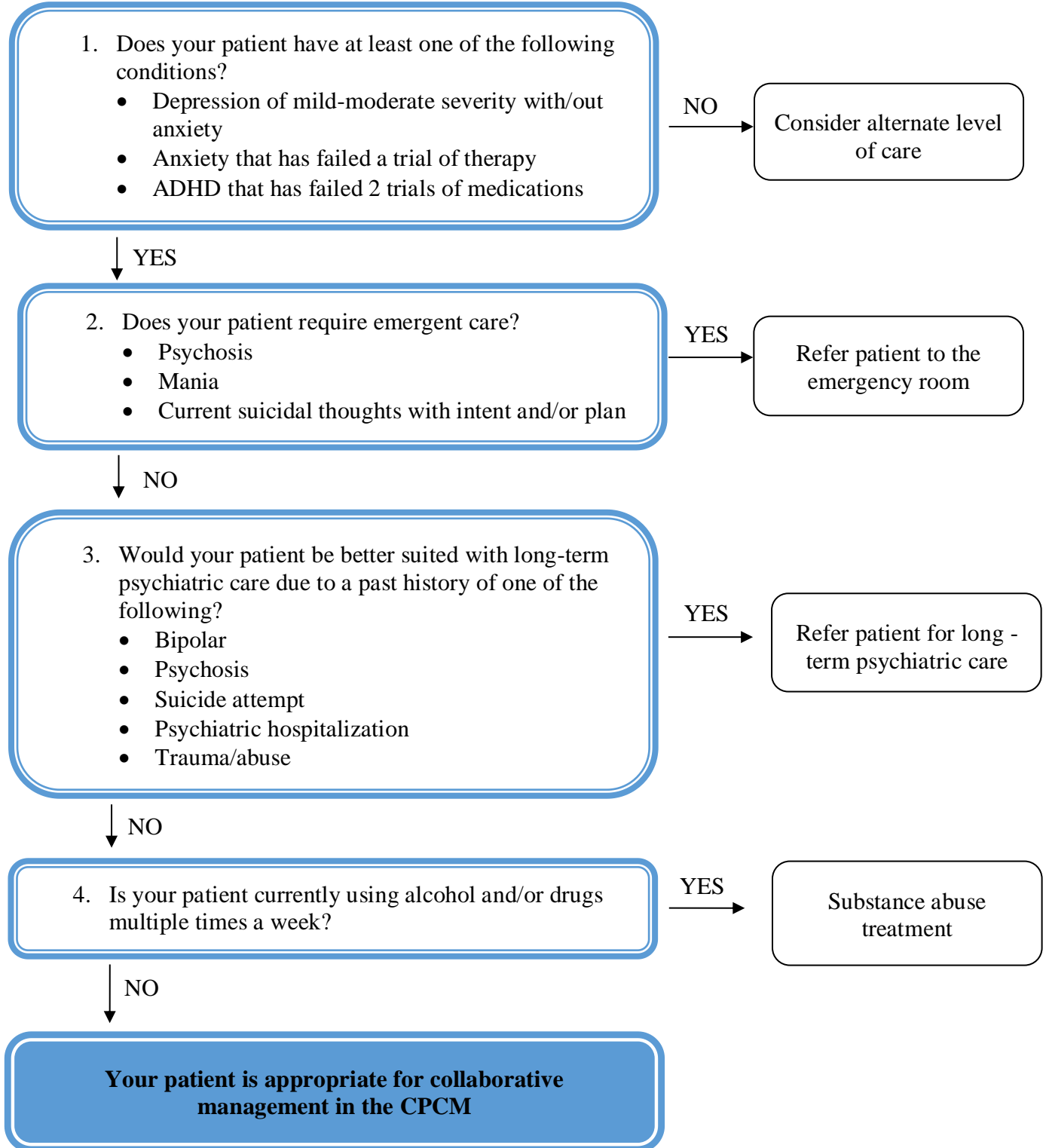


Please make sure that your CCI Referrals have the following information:

- Completed REFERRAL FORM with correct insurance and contact information for the patient
- FACE SHEET
- Most recent CLINIC NOTE

Collaborative Care Psychiatry Consultation

How do you know if your patient would benefit from the Child Psychiatry Consultation Model?



Collaborative Care Model: Psychiatry Providers and Insurance Information

University of Florida Psychiatry

Please **FAX** referral forms and your most recent clinical note to: (904) 383-1660

Attention: Sharon Richards

Phone: (904) 383-1656

Locations:

DuPont Station
6266 DuPont Station Ct
Jacksonville, FL 32217

Now Accepting Referrals:

- Dr. Aylin Emmert, MD
- Dr. Victor Santos, MD
- Dr. Allison Nussbaum, MD

UF Health is “in-network” for:

Aetna

BCBS

Capitol Health Plan

Cigna

GatorCare

Humana (commercial plans)

MHNet

Tricare (Standard)

United Behavioral Health (Commercial)

<http://partnershipforchildhealth.org/center-for-collaborative-care/>



Collaborative Care Psychiatry Consultation Request Form

UF Health:

Please **FAX** request form, face sheet and your most recent *clinical note* to **(904) 383-1660**

Attention: Sharon Richards

Phone: (904) 383-1656

Patient Name:	Date of Birth:
Patient Phone #:	Health Insurance and policy #:
Patient Primary Language:	
Service Requested: <input type="checkbox"/> Collaborative Care Model: consultation and up to 3 follow-up visits with plan for patient to return to PRIMARY CARE provider for long-term psychotropic medication management	
Does the patient have a past history of bipolar, psychosis, or psychiatric hospitalization?	
<input type="checkbox"/> Yes; <i>If so, please refer instead to Psychiatry for Traditional Care</i>	<input type="checkbox"/> No
Is the patient currently using alcohol and/or drugs multiple times a week?	
<input type="checkbox"/> Yes; <i>If so, please refer instead for substance abuse treatment</i>	<input type="checkbox"/> No
Reason for Consult: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other (describe):	
Current symptoms of mental illness and changes in school/home functioning:	
Has the patient tried psychotropic medication? <input type="checkbox"/> Yes (please list medications) <input type="checkbox"/> No	
Is the patient currently being treated with psychotherapy?	
<input type="checkbox"/> Yes (by whom)	<input type="checkbox"/> No
Score on Patient Health Questionnaire – 9 Item (PHQ9), if relevant:	
Score on SCARED, if relevant:	

Name of Referring PCP:	
Fax# for Referring PCP:	Phone # for Referring PCP: